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Patient dignity in mental health care: from inherent worth to standing

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Abstract

Respect for patient dignity is recognized as an ethical commitment in healthcare, yet the concept often remains too abstract to guide clinical practice. This challenge is salient in mental health contexts, where patients may experience diminished autonomy, stigma, or institutional constraints. This paper develops a conceptual and normative analysis of dignity in mental health care by distinguishing between two conceptions: dignity as inherent worth and dignity-as-standing. Drawing on philosophical analysis, empirical literature, and global policy frameworks, the paper evaluates each conception's practical implications for care. We argue that while dignity as inherent worth understands dignity as an intrinsic, non-natural value grounding human rights, it often remains too vague to guide clinical decision-making and may risk excluding patients with diminished autonomy. By contrast, dignity-as-standing conceives dignity not as a metaphysical value but as the elevated moral standing of persons that calls for treatment befitting their rank as members of the moral community. This conception offers a more action-guiding and inclusive framework for care, especially for patients with mental illness, disabilities, dementia, or advanced age. On this basis, we identify strategies for operationalizing dignity in practice, including recognizing autonomy as a continuum, implementing supported decision-making, respecting value-based refusals, and embedding relational, structural, and culturally responsive supports in care. The dignity-as-standing framework offers a practical and ethically coherent foundation for respecting patients' dignity in mental health care, enabling clinicians and institutions to translate the ideal of dignity into concrete practices across diverse clinical and cultural contexts.

Keywords: *dignity, respect for persons, mental health, older persons, disability, cultural inclusion*

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1. Introduction

In healthcare ethics, calls to respect patient dignity have become increasingly prominent in recent years. This is partly due to a major demographic and health transition. Today, one in 10 people are aged 65 or older; by the late 2070s, this will rise to about one in five, with their numbers exceeding those of children under 18 [1, 2]. Mental health conditions affect one in eight people [3], often within care contexts marked by stigma, coercion, and challenges to the protection of patients' rights. At the same time, dementia cases are expected to rise from 55 million to 139 million by 2050 [4]. Disability rates are also increasing, affecting 1.3 billion people worldwide—nearly one in three older adults [5].

Globally, key treaties and policy frameworks affirm that people with mental health conditions and/or disabilities, as well as older adults, must be treated as equals. Binding instruments such as the UN Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) [6], the UN Sustainable Development Goals (2015) [7], and the Madrid International Plan of Action on Ageing (2002) [8] set system-wide commitments, while non-binding yet norm-shaping initiatives, including the UN Committee on the Rights of Persons with Disabilities (2008) [9], the WHO Comprehensive Mental Health Action Plan (2013–2030) [10], and the UN Decade of Healthy Ageing (2021–2030) [11], advance person-centered, non-coercive care.

In mental health, these frameworks increasingly converge on a rights-based paradigm shift: moving away from institutionalization, substitute decision-making, and coercive interventions, and toward supported decision-making, participation, and community-based services. In particular, the UN Human Rights Council Resolution 43/13 (2020) [12] urges states to integrate a human rights perspective into mental health and community services and to promote community-, evidence-, and rights-based supports, explicitly prioritizing autonomy, will and preferences, and voluntary supported decision-making (including peer support) over coercion and institutionalization. Complementing this normative mandate, the WHO QualityRights initiative provides standards, assessment tools, training, and guidance on law and policy reform to improve quality and human rights in mental health and social care [13].

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This evolving international framework marks a clear policy shift toward dignity in healthcare, reflecting the universalist notion of dignity in the Universal Declaration of Human Rights (1948) that "*all human beings are born free and equal in dignity and rights*" [14].

Despite this universalist focus, people with mental disorders are often denied recognition as valued individuals and continue to face serious human rights violations in care settings [15]. Around the world, many individuals with mental illness experience coercive practices such as involuntary detention, forced treatment, seclusion in bare rooms, and physical restraint [16, 17]. Although often justified by paternalism and public safety, such measures are commonly experienced as humiliating, frightening, and retraumatizing [18]. Beyond overt coercion, psychiatric patients also report routine dignity violations: being ignored by staff, excluded from decision-making, denied information, and treated as objects rather than persons [19]. These clinical practices reflect a broader social context of stigma, in which people with mental illness are perceived as dangerous or incapable, eroding their social standing and legitimizing exclusion from education, employment, housing, and community life [20]. Moreover, perceived stigma is associated with greater depression severity [21] as well as diminished self-worth and poorer quality of care [22].

At the same time, research shows that ageism significantly worsens health outcomes, entrenches systemic barriers to treatment access and quality, and perpetuates the exclusion of older adults from medical research [23]. A persistent, cross-cultural age bias has been further confirmed by the World Health Organization's Global Report on Ageism [24] and the large-scale Moral Machine study on autonomous vehicle ethics, which reveal that even in cultures that traditionally venerate elders, older lives are often implicitly devalued [25]. This shows that although the principle of equal dignity is enshrined in treaties, policy frameworks, and initiatives, deep-seated biases continue to shape practice. The persistence of implicit biases among healthcare professionals—linked to poorer communication and care—confirms this [26]. In this context, it is not surprising that dignity-based healthcare often remains a theoretical ideal, which is overlooked in daily clinical settings [27].

However, far from being merely a lofty ethical ideal, dignity has direct clinical relevance. Research demonstrates that dignified care improves patient satisfaction, adherence, preventive care, and recovery [28, 29], while neglecting dignity can fuel depression, anxiety, stress, and diminished quality of life [30, 31]. In light of this, it is crucial to underscore the importance of dignity-based healthcare and to take concrete steps toward its realization.

What could these steps involve? It is important to note that without a clear understanding and genuine acceptance of the moral equality of every person, dignity-centered initiatives risk becoming hollow gestures. Policies alone cannot eliminate injustice if implicit attitudes remain untouched; structural ageism, sanism, and ableism will continue to perpetuate disparities, creating a risk of superficial adherence. For instance, caregivers may follow certain protocols, such as using polite language, yet still unconsciously regard a 90-year-old with a mental health condition as less of a "*full person*" than an independent adult. Such attitudes, even when unintended, can subtly shape behavior and gradually steer us away from the goal of truly dignity-centered care.

Implementation-oriented research on dignity-centered care therefore identifies several recurring key steps for translating dignity commitments into healthcare practice and its broader social conditions. One such step is to optimize and expand implicit bias training for healthcare professionals. Evidence suggests that the mechanisms of cognitive-behavioral therapy (CBT) and other habit-breaking techniques, when practiced repeatedly, can produce long-term reductions in implicit bias among healthcare providers [32, 33]. Another is to foster societal attitude change through anti-stigma and anti-discrimination campaigns in mental health, disability, and aging, such as the UK's Time to Change program (2007–2021), Canada's Opening Minds initiative (2009–present), and the Canadian Coalition Against Ageism (2022–present).

A further step—one that this paper takes up directly—is to address the conceptual inconsistency surrounding dignity. Although often criticized as a contested and vague notion [34], the absence of a shared understanding among healthcare professionals about what dignity means and encompasses can translate into real risks of violating patients' dignity. For instance, some staff emphasize upholding a patient's pre-disease identity while others focus only on the present self, a divergence that can lead to either disregarding current needs or erasing personal history [27]. Developing a common conceptual ground and clear definition is therefore essential to prevent misunderstandings and ensure genuinely dignified care [35].

Our paper seeks to clarify this inconsistency by examining two leading conceptions of dignity—dignity as inherent worth and dignity-as-standing—and by arguing for the importance of incorporating the latter alongside the former. We contend that dignity-as-standing offers a more relational and contextual framework, one that is less mired in abstract theoretical debates and more directly translatable into clinical norms. By grounding dignity in a richer conception of what a human being is, rather than in a thin conception that merely holds that humans are precious, it provides a clearer, action-guiding, and culturally inclusive framework for healthcare practice. This makes it especially well-suited for complex cases—such as mental illness or dementia—where autonomy is partial or fluctuating. In short, dignity-as-standing offers a practical and ethically robust foundation for moving dignity from a lofty principle to a lived reality in healthcare.

2. Two conceptions of dignity

Respecting the dignity of a patient is an important imperative in medical ethics. But what exactly is dignity and what, more specifically, does respecting dignity require from us? The aim of this section is to clarify the notion of dignity and to see what normative requirements follow from it. As we shall argue, there are at least two main conceptions of dignity. One is the familiar one from contemporary debates that conceives of dignity as an absolute, inner value of human beings, an inherent preciousness. But there is a much older conception according to which dignity is a high rank or impressiveness of human beings. We shall argue that it is very fruitful to include this second conception in debates on medical ethics.

2.1. Dignity as inherent worth

The first notion that dignity is a value related to the preciousness of human beings is familiar from UN declarations and bioethics covenants. The founding Charter of the UN, for instance, seems to specify human dignity as the worth of human beings:

> *"We the peoples of the United Nations determined […] to reaffirm faith in fundamental human rights, in the dignity and worth of the human person, in the equal rights of men and women and of nations large and small […] and for these ends […] have resolved to combine our efforts to accomplish these aims".* ([36], p. 2)

The UN Convention on the Rights of Persons with Disabilities states this more explicitly when it starts out: "*Recalling the principles proclaimed in the Charter of the United Nations which recognize the inherent dignity and worth and the equal and inalienable rights of all members of the human family as the foundation of freedom, justice and peace in the world*" ([6], p. 1). Here, dignity is explained as an inherent worth that all human beings possess. Some UN documents state that this kind of dignity is the basis of human rights:

> *"The States Parties to the present Covenant, […]*
>
> *Recognizing that these rights derive from the inherent dignity of the human person […],*
>
> *Agree upon the following articles: […]".* [37]

There are different ways in which one can understand a statement that human beings have an inherent worth. International covenants deliberately leave the key notions vague in order to secure agreement between parties from very different cultures ([38], p. 10). But philosophers who reflect on inherent worth often regard it as a separate metaphysical property. It is not necessarily a natural property that could be directly observed, for example, by a surgeon during an operation. If one could view a human being through an ontological X-ray that revealed everything a human being is made of, one would not only see familiar natural properties such as bones, cells, and bodily fluids; one would also see what a mind is, what a self is, and—crucially—a value property understood as an "*inherent, intrinsic preciousness*" ([39], p. 96).

According to this conception, "*dignity*" is the name of a value all human beings possess, and this value is the reason why one should respect others:

> *"When we speak of the dignity of human life, we mean an objective and intrinsic value. We speak of a value and intrinsic goodness greater than, and different from, a modest aesthetic value of an ornament or the intellectual value of a chess player […], which do not directly impose moral imperatives on us. Instead, when we speak of human dignity, we speak of morally relevant value, one which evidently imposes on us a moral call and an obligation to respect it".* ([39], p. 97)

According to this view, dignity is an inherent value. If the only thing that existed in the world were a single human being, that individual would carry this value intrinsically. In addition, this value is not something one can directly discover through any of the five senses: "*As life, and human life, this value called 'dignity' is an ultimate and irreducible phenomenon which cannot be defined properly speaking but can only be unfolded and brought to evidence*" ([39], p. 98). Instead of being a natural property that one can discover through the senses, dignity is considered to be a non-natural, inherent property that can only be detected by intuition. This interpretation reflects G.E. Moore's non-naturalist value realism and his intuitionist account of how such values are known [39, 40].

This conception of dignity, understood in value realist terms, can easily explain why human beings are owed a distinctive kind of moral respect. If everyone is inherently precious and valuable, it seems appropriate to treat everyone as such and respect them in medical settings. However, at a philosophical or metaethical level, Moore-style value realism faces several familiar objections. First, as John Mackie argues [41], if objective, irreducibly normative values existed, they would be metaphysically and epistemically puzzling, requiring both non-natural properties with an intrinsic "*to-be-pursuedness*" unlike anything else in the natural world and a special faculty of moral intuition to know them. Second, this view faces difficulties in explaining pervasive and culturally patterned moral disagreement—often taken to support relativism—beyond appealing to widespread error. Finally, from a David Humean perspective, questions remain as to how objective values, so understood, are supposed to motivate action.

In addition to these critiques, dignity as inherent worth accounts give rise to two further problems: (1) the action-guidance problem and (2) the moral exclusion problem. First, while this conception can easily explain why human beings are owed a distinctive kind of moral respect, it is less clear what more specifically one should do to respect someone. Second, there is a danger that such a conception does not consider patients at the margins, e.g., people with mental illness or dementia.

The first problem is an issue of application or how one can derive concrete duties from a concept of dignity. Just saying that someone is inherently precious does not clarify what one should do to respect the other. Take, for instance, a case in which a patient who suffers greatly asks for euthanasia or physician-assisted suicide. Does one treat the patient as precious if one follows her wishes or if one preserves the precious life even against her wishes? There is no clear answer that is decided by referring to the concept of dignity as a value. Regarding someone as precious is compatible with paternalism. We might regard an art piece as inherently precious and priceless, but we determine how it is kept and preserved.

A second problem is that the contemporary dignity as inherent worth accounts risk excluding people at the margins. This is because scholars often attach dignity to a human capacity, such as autonomy or the ability to make informed decisions on one's own behalf. But if this decision-making capacity is what confers intrinsic worth and dignity, then those who lack that capacity in full would, by that logic, lack intrinsic worth and dignity. This implication is especially troubling in clinical contexts where autonomy is partial, fluctuating, or absent, yet where respect and protection remain ethically central.

Moreover, autonomy is not only an individual capacity but is also socially shaped. Structural factors such as poverty, racism, colonialism, ableism, homophobia, transphobia, and other forms

of exclusion can significantly undermine a person's ability to exercise self-governance. Historically, these same forces have been used to deny dignity to subordinated groups while affirming it for dominant ones. Tying dignity to autonomy therefore risks converting social injustice into moral exclusion.

There is another conception of dignity that can give a better answer to these problems.

2.2. Dignity as standing

Dignity as the name for a precious value is not the only conception of dignity, and one can argue that in the long history of philosophy it is relatively new [42, 43]. According to the older notion, "*dignity*" refers to a high rank or elevated standing of someone over something else. It is not a property that one could see under an ontological X-ray if one looks at a being in isolation. Rather, it is a comparative term that says that one item (e.g., a human being) is elevated or raised above another item (e.g., inorganic matter) in a certain respect. For instance, it was a traditional view that human beings are special in nature by virtue of having reason and freedom. Cicero writes:

> *"But it is essential to every inquiry about duty that we keep before our eyes how far superior man is by nature to cattle and other beasts: they have no thought except for sensual pleasure and this they are impelled by every instinct to seek; but man's mind is nurtured by study and meditation".* ([44], I 105)

"*Dignity*" here expresses not that a being—regarded in isolation—is absolutely precious, but it expresses a superiority or higher rank of one being (human beings) over another (e.g., cattle) in a specified respect (here, rational self-governance). This notion of dignity, rooted in the Roman concept of "*dignitas*", was not only used to compare human beings to the rest of nature, but to compare any two items and say that one of them is raised above the other on a certain scale. One could talk about the dignity of the emperor, of a teacher, mathematics, a parent, or the goldsmith's guild [45]. Cicero was the first thinker to use the concept of dignity in a universalized way; that is, to apply it to all human beings as such, rather than to a restricted class [45].

This form of dignity is a richer conception that includes a description of what the particular being that has dignity is and therefore provides a more direct way of explaining how one should treat this being appropriately. In a first instance, if one occupies a certain rank, one should behave according to one's rank. If one does not, one's initial dignity remains unrealized or is wasted [38]. This contrasts with the dignity as inherent worth conception, according to which dignity is possessed as such rather than realized through one's actions. The above-cited passage from Cicero continues:

> *"From this we see that sensual pleasure is quite unworthy of the dignity of man and that we ought to despise it and cast it from us; […] And if we will only bear in mind the superiority and dignity [excellentia et dignitas] of our nature, we shall realize how wrong it is to abandon ourselves to excess and to live in luxury and voluptuousness, and how right it is to live in thrift, self-denial, simplicity, and sobriety".* ([44], I 106)

Because human beings have reason and are not wholly determined by their desires and passions, Cicero argues, they are special or uplifted over beings that are slaves to their passions. To live as human beings, we should not just give in to every passion, but use our reason.

From this conception of dignity come ideas such as "*dying with dignity*". "*Dignity*" here does not mean "*value*" or "*preciousness*", so that the expression could also be used as saying: "*Dying with preciousness*". Rather, the idea is that if one becomes master over one's passions and fear of death, one can die with composure and restraint. Using one's reason, or acting on good reasons, may sometimes require going against one's strongest desires and inclinations, and this is compatible with "*dying with dignity*" taking different forms: one may choose euthanasia or physician-assisted suicide for autonomy-related reasons, or reject life-sustaining treatment to let nature take its course, despite an overwhelming desire to continue living. (The same understanding of reason and freedom can also ground accounts of "*living with dignity*": for example, one may continue living and accept intensive medical intervention and dependence for reasons such as narrative coherence, companionship, relational continuity, and religious or spiritual commitment, even in the face of ongoing pain and a powerful impulse to avoid it).

It is worth clarifying one point here. Contemporary scholarship may regard Cicero's view as outdated, especially given that some non-human animals display sophisticated cognition and tool use and may even have a primitive sense of fairness and altruism. However, this does not undermine the 'elevated status' structure of the concept. For example, humans may have an elevated status by virtue of possessing the capacity for normative thought. It might be argued that, despite some animals displaying sophisticated abilities such as tool-making, they do not reflect on whether they have good reasons for acting. They may want to be loved and cared for, but, unlike humans, they do not reflect on whether they are worthy of love or care. If this is true, then they lack the capacity for normative thought. If this is not true and some animals do possess a capacity for normative thought, it is still sufficient for human beings to have an elevated status insofar as they exhibit a higher degree of rationality and normative thought.

More importantly, this elevated status does not imply moral superiority or greater moral consideration. The dignity-as-standing conception begins with a factual description of why one being is elevated over another and does not posit a morally loaded value property that grounds rights, as dignity as inherent worth does. Rather, it only describes different kinds of beings with different capacities. Thus, the fact that humans have reason and freedom does not by itself entail moral superiority, greater moral consideration than animals, or less consideration for humans with reduced autonomy. This special position of having reason and freedom generates the duty to make a proper use of those capacities only when combined with an additional normative premise.

By way of illustration, many animals are special in nature. A cheetah is the fastest land animal, a whale the biggest mammal, and insects can climb walls. These descriptive facts do not entail the normative statements that a cheetah ought to run fast, a whale ought to be large, or insects ought to climb walls, unless they are supported by an additional normative premise. Similarly, it needs an extra argument as to why one should use one's reason and live up to one's dignity. For the Stoics this was the command to

live according to one's nature: "*It is pointless to go to war with nature and to aim at something which we cannot achieve*" ([44], I 110). In religious traditions of the Middle Ages, this was often the command to live up to the image of God; in the Renaissance it was to use one's freedom [42]. More generally, the framework does not depend on any particular historical formulation, and one may appeal to a different normative premise. In that case, it would be unsurprising that, by using one's reason properly and living up to one's dignity, one can recognize more specific duties compatible with extending moral consideration to patients with diminished or fluctuating autonomy (e.g., mental illness), to cultures with different views, to animals, and to the environment.

That said, historically, different dignity-as-standing accounts have understood the scope of the duty to exercise one's special capacities (e.g., reason) in different ways. Early accounts focused less on how one should treat others than on how one realizes one's own dignity through self-perfection. According to this version of dignity-as-standing, those who fail to exercise their special capacities and instead live like cattle do not live up to their full potential and thereby violate a duty to the self. Later accounts, especially those emerging during the Industrial Revolution, extended this idea to interpersonal claims, using the notion of living up to one's rank to articulate what one human being may demand from another.

The idea of living up to one's rank is also familiar from the more individual notion of dignity. An emperor might have been said to walk or speak with dignity, or to behave in a dignified manner. We are familiar with the complaint that a certain type of work might be below one's dignity. As such, one can make a claim on others to respect one's standing and treat one appropriately.

This notion became especially prominent during the Industrial Revolution of the 19th and early 20th century. Scholars writing about dignity began to refer to the concept of a "*dignified existence*" [46]. In the large cities of the Industrial Revolution, families of 20 might live in a one-bedroom apartment, and workers might spend their entire lives underground in coal mines. Appeals to dignity expressed the idea that human beings should not live like cattle but have a claim to conditions worthy of human beings. On our account, this historical shift indicates that dignity-as-standing is a flexible normative framework: once paired with a suitable moral premise, it can expand from duties to self to claims about the conditions and practices of treatment and care that respect patients—especially those with mental illness—in ways befitting their standing.

We argue that one should include the dignity-as-standing conception in discussions of how one should respect patients. This is because it can deal in a better way with the two objections against the dignity as inherent worth notion. First, dignity as what makes us special in nature can be very fruitful in determining how one should treat a patient. Second, the conception can also include patients at the margins, such as people with mental illness.

First, a human being is not just an isolated entity. Human beings stand in relationships and have a history. These relationships can extend far beyond blood ties. In many indigenous cultures, personhood is defined through relations with kin, community, and ancestors. Such collective notions of identity shape the understanding of dignity in these cultures. A clear illustration of dignity as collective standing is the African concept of Ubuntu, a philosophy of interconnected humanity. According to this view, confining a person with mental illness in degrading conditions is not merely an individual wrong but a stain on everyone's humanity: we are not fully human as long as we allow that to happen. In this way, Ubuntu dovetails with dignity-as-standing, which distinguishes between an initial dignity grounded in standing and a dignity that is realized or wasted through how individuals and communities act toward one another. Failures of respect may therefore result in a moral loss for all and, in this sense, reflect a failure to realize dignity as collective standing. This shows that, despite cultural variation in how dignity is understood or applied (for example, as individual or collective standing), dignity-as-standing is flexible enough to engage with—rather than overwrite—collective and relational understandings.

Humans do not just have a capacity to make decisions, but also have feelings, values, and a conception of their fragility and vulnerability, which can take normative priority in determining how to uphold dignity. For example, E.K. Feder highlights the "*dignity of vulnerability*" in intersex cases, arguing that the problem lies not in atypical anatomy but in medicine's and society's intolerance of sexual ambiguity. Rather than "*protecting*" children from difference through irreversible surgical interventions, she contends that their vulnerability should be protected by preserving bodily integrity until they can meaningfully participate in decision-making [47]. This supports the idea that dignity is not exhausted by current decision-making capacity and that, when detached from vulnerability and future agency, appeals to dignity can serve to justify coercive and harmful practices. Moreover, empirical work in long-term care and residential mental health settings suggests that framing sexual intimacy primarily in terms of autonomy and consent-driven risk management can crowd out other morally salient values such as care, relational meaning, and well-being [48–50].

The dignity-as-standing conception includes a description of the kind of being that bears dignity, or of the capacities that confer an elevated status in nature. This description is informed by empirical research across different fields (e.g., anthropology, medicine, psychology, sociology, history, and cultural studies) that sheds light on the complexity of human capacities across biological, psychological, and social domains. Thus, this conception allows us to give a much richer and more dynamic picture of what a human being is, accommodates cultural inclusion, and thereby informs how we should respect a particular patient and what counts as a dignified existence, by clarifying which features of humans may be normatively salient in different contexts.

Second, the dignity-as-standing account does not merely ask us to respect competent adults in the maturity of their faculties. An elderly patient might be a beloved grandmother who for decades has been the glue of her family. If she loses some of her faculty to make autonomous decisions, this does not mean that she loses all her standing as a valued member of the community. Likewise, a person with severe mental illness may not be fully autonomous; yet this does not entail involuntary care, coercion, rights violations, or stigma within psychiatric services. Such individuals remain members of our shared moral family, where each person's dignity is bound up with that of others. The richer dignity-as-standing conception gives us a more nuanced understanding of how one should treat patients with respect relative to maturity or decline of their faculties (**Table 1**).

Table 1 • Two conceptions of dignity.

Dimension	Dignity as inherent worth	Dignity as standing
Meaning	Dignity is the inherent, intrinsic value of every human being.	Dignity is the elevated standing or rank of human beings that calls for appropriate treatment.
Ontology	A non-natural, metaphysical property of persons, not observable but part of what a human being is.	A relational and comparative concept describing one's place or status among others.
Source	Grounded in Moorean value realism and intuitionism, human rights discourse (e.g., UN Charter), and the claim that human life is inherently precious, where dignity is treated as a self-evident, intrinsic value.	Rooted in historical and philosophical traditions (e.g., Stoicism, civic and social roles) emphasizing reason, self-mastery, and the idea that humans are raised above other beings.
How it is known	Recognized through intuition or "brought to evidence", not defined empirically.	We determine what is truly human and what makes us unique through scientific research in fields such as anthropology, medicine, psychology, sociology, history, and cultural studies.
Moral function	Explains why all humans must be respected equally.	Guides how to respect persons in concrete interactions.
Strengths	Strong foundation for moral equality and universal rights.	Action-guiding; allows attention to identity, history, culture, and relationships.
Limitations	Can be too abstract for clinical application; risks linking dignity to autonomy, potentially excluding those with diminished capacity.	Historically associated with status hierarchies, so must be grounded in the modern claim that all humans share the same standing.
Implications for patients with mental illness or cognitive disability	If dignity is tied to rational decision-making, such patients may be seen as having less dignity.	Dignity is maintained even when autonomy fluctuates, because standing is based on belonging and recognition, not cognitive ability alone.

This does not mean that we should discard the contemporary notion of dignity as inherent worth or that it is false. It can explain well why we regard human beings as important. But there are good reasons to also include the older conception of dignity as standing in our discussion of how to respect patients.

2.3. Further clarifications

How does our distinction between dignity as inherent worth and dignity as standing relate to established distinctions in contemporary bioethics and biolaw, particularly those developed by Beyleveld and Brownsword [51] and by Daryl Pullman [52–54]? Before turning to the practical application of our preferred conception of dignity, we shall address this question.

According to Beyleveld and Brownsword [51], dignity operates in two distinct ways in bioethics and biolaw: as dignity as empowerment, which emphasizes decision-making capacity and supports autonomy protections, and dignity as constraint, which limits autonomous choices in the name of collective or protective values (such as integrity, vulnerability, or solidarity) and extends protection to beings lacking autonomy (e.g., fetuses). Our distinction differs in scope and aim. Beyleveld and Brownsword [51] offer a functional or regulatory account of how dignity is used in contemporary European bioethical and legal discourse, highlighting its dual regulatory role. By contrast, our distinction concerns what dignity *is*, not merely how it is applied, and it includes both conceptual and ontological dimensions. In our view, dignity as empowerment and dignity as constraint can be understood as alternative cultural or legal interpretations of a single underlying conception of dignity (whether dignity as inherent worth or dignity as standing). In this sense, our distinction is complementary to their account: whereas their analysis operates primarily along a functional axis, ours offers a conceptual and ontological basis together with normative clarification by engaging questions such as why and how dignity, if one takes it as the capacity for autonomy, can yield rights or moral obligations—questions that a purely functional focus cannot directly answer.

Let us also compare our distinction with Pullman's [52–54] distinction between basic dignity and personal dignity. Basic dignity is universal, inviolable, and an objective feature of human existence: it is an unearned, intrinsic value that every human being possesses and that is not contingent on individual circumstances and volition. Personal dignity, by contrast, concerns how dignity is interpreted and expressed within particular social and cultural contexts. As such, it varies across cultures, historical periods, and social norms. Although personal dignity is often associated with autonomy and control—especially within liberal-humanist traditions—it permits alternative interpretations, such as African Ubuntu.

Pullman's central objection is that contemporary debates tend to overemphasize personal dignity at the expense of basic dignity. Because personal dignity is frequently tied to autonomy and control, it risks supporting exclusionary practices toward patients with diminished autonomy, including those with mental illness, insofar as they may be regarded as lacking dignity. Yet, as Pullman emphasizes, "*considerations of basic dignity exert moral force even in the absence of autonomy*" ([52], p. 38). This commitment underlies his critique of Beyleveld and Brownsword's account [51], which he (rightly) argues is best understood as advancing competing versions of personal dignity—one individualistic and one communitarian.

Pullman's notion of personal dignity captures the fact that different cultures understand dignity in different ways, a point with which we agree. However, this leaves Pullman with only one primary notion of dignity—basic dignity—while personal dignity appears to function merely as a set of culturally variable interpretations of that basic concept. Dignity as standing, unlike personal dignity, is not a relativistic conception grounded in cultural opinion. Rather, it is grounded in distinctive human qualities identified through empirical research. Moreover, as explained above, these qualities (e.g., the capacity for autonomy) do not automatically confer moral status or rights, and thus dignity as standing avoids the exclusionary risks that autonomy-centered accounts of personal dignity can generate for patients at the margins. Pullman therefore does not appear to consider the plausibility of dignity as standing as a distinct alternative.

Pullman's notion of basic dignity is open to three readings. First, it might be understood as a metaphysical value property akin to dignity as inherent worth. On this reading, it would inherit the same problems of vagueness, limited action-guidance, and moral exclusion that we raised against that conception. Second, it might be read as a substantive normative thesis: that any morality denying humans an objective, unearned, inviolable, intrinsic dignity is not worth having. On this interpretation, the view risks becoming question-begging.

We do not think Pullman intends either of these readings. This is suggested by his characterization of basic dignity as "*ascriptive*", a "*logical primitive*", a "*formal meaning constraint*", and an "*epistemic boundary on what passes as meaningful moral discourse*" ([54], p. 360). On this third reading, basic dignity is not a psychological fact or metaphysical value property, but a status that must be ascribed to humans for moral discourse to be intelligible at all. This is best understood as a transcendental or constitutivist move: whatever the metaphysics, treating humans as lacking intrinsic dignity or moral status would preclude meaningful moral thinking and discourse.

Even so, this ascriptive, non-capacity-based conception may appear vague or arbitrary: why humans, and in virtue of what? Pullman's likely response is that ascribing basic dignity to humans is a condition for the possibility of meaningful and intelligible moral discourse. If so, critics would need to supply counterexamples: normative theories that deny dignity to at least some humans without collapsing into unintelligibility—such as ethical egoism or other exclusionary frameworks—regardless of their moral plausibility.

Our aim here is not to argue that dignity as standing is more plausible than these alternatives. Rather, it is to show that our conceptions of dignity differ from those advanced by Beyleveld and Brownsword [51] and by Pullman [52–54]. In this way, our approach adds conceptual richness to existing distinctions and can complement them independently of the questions of plausibility.

3. Dignity in action: autonomy, support, and relational-structural care across cultures

Taking dignity-as-standing as our guide, this section shows how to turn the ideal into clinical practice. If respecting dignity means treating people as entitled to equal recognition and regard, care must preserve that standing even when autonomy is partial or fluctuating. We outline five operational strategies: recognize autonomy as a continuum, enable supported decision-making, respect value-based refusals, sustain dignity through relational and structural support, and ensure that these practices remain culturally inclusive to how dignity is expressed and protected across contexts (**Table 2**).

3.1. Recognizing autonomy as a continuum

Healthcare law and policy often treat autonomy as contingent on an all-or-nothing notion of decision-making capacity: a patient is either deemed competent to decide, or authority shifts to a proxy or physician. This binary framework is reflected in statutes that presume competence unless proven otherwise and require a formal finding of incapacity before overriding a patient's choices. For instance, New York Public Health Law § 2981 states that "*every adult shall be presumed competent to appoint a health care agent unless such person has been adjudged incompetent or otherwise adjudged not competent to appoint a health care agent*" [56].

In practice, however, clinicians and ethicists increasingly recognize that autonomy is not binary but gradational and dynamic [57–59]. As Lahey and Elwyn note, "*decision-making capacity is far from a binary phenomenon: it can be whole, partial, or absent, and varies from decision to decision as well as from time to time*" ([60], p. 359). This perspective reframes capacity not as a fixed threshold but as a continuum that can expand or contract depending on the complexity of the decision, the patient's health status, emotional state, or the context of care.

Upholding dignity under this model requires clinicians to engage patients as much as possible in decisions that concern them, even when their comprehension is limited. Patients with schizophrenia or bipolar disorder may express meaningful preferences and values about their care and, with appropriate supports, are often able to participate in decisions even when they struggle to understand complex disclosures [61]. Similarly, a patient with moderate dementia may not understand every medical detail, yet might meaningfully express preferences about comfort, family presence, or daily routines. A frail older adult receiving opioid medication might be fully lucid in the morning but cognitively dulled later in the day. Recognizing these gradations allows care to remain participatory and respectful, rather than paternalistic.

This approach also demands flexibility in communication: simplifying explanations, using visual aids, engaging patients at optimal times of alertness, and framing choices in concrete, personally meaningful terms rather than abstract medical options. Such practices affirm the patient's status as an agent—someone to be reasoned with, not managed. In this way, the continuum model aligns with dignity as standing*:* even when autonomy is partial and fluctuating, the person remains a moral subject entitled to recognition and participation in decisions affecting their life.

3.2. Supported decision-making

Supported decision-making (SDM) extends the continuum model of autonomy by providing concrete means to preserve agency within dependency. Rooted in Article 12 of the UNCRPD [6], SDM resists the premature shift to substitute decision-making, enabling individuals to decide for themselves with the assistance they need whenever possible.

Table 2 • Translating dignity as standing into clinical practice.

Domain	Core action	Concrete behaviors	Example documentation	Measurement/indicator
Autonomy as continuum (Section 3.1)	Treat autonomy as gradual and fluctuating, not all-or-nothing	Simplify explanations; use visual aids; engage patient at best time of alertness; frame choices in personally meaningful terms	"Patient with moderate dementia participated in discussion when rested in the morning and clearly expressed preference for family presence and comfort-oriented daily routine."	Patient-reported involvement in care; comprehension confirmation; flexible timing of capacity discussions
Supported decision-making (Section 3.2)	Support agency through relationships, not independence	Involve trusted persons; allow extra time; use interpreters; clarify and restate values; avoid premature proxy decision-making	"Supported discussion held with long-known caregiver present; patient consistently affirmed desire to remain at home despite limited cognitive recall of details."	Rate of supported decision-making use; interpreter availability; documentation of patient values during supported decision-making
Value-based refusals (Section 3.3)	Respect refusals based on life goals or burdens, not only rational comparison	Ask what matters most; identify intolerable burdens; look for stable, repeated expressions of value	"Patient declined burdensome intervention because maintaining ability to walk in garden and interact with grandchildren was identified as core life goal."	Documentation of value rationale; ethics consult outcomes aligning with documented overriding values; consistency of expressed goals
Relational supports (Section 3.4)	Protect dignity through communication, privacy, gentleness, and presence	Address patient directly; preserve privacy during care; explain actions; listen; minimize coercion; avoid depersonalizing habits	"Staff spoke directly to patient, closed door during care, explained each step, and allowed time for emotional expression rather than rushing."	Patient dignity/respect scores; reduced use of restraint or forced measures
Structural supports/policy design (Section 3.4)	Build systems that prevent social marginalization from becoming moral exclusion	Use community and peer support roles; ensure provider and care continuity; assist with housing and transportation; integrate social determinants into care planning	"Care team maintained provider and care continuity, arranged community support for transportation to appointments, and coordinated communication among family and clinicians."	Indices to measure continuity of care, such as Continuity of Care Index (COC) [55]; rate of referrals to community health workers (CHWs) and social support services; reductions in missed care due to logistical barriers
Cultural inclusion (Section 3.5)	Express dignity in culturally meaningful ways, not one uniform method	Ask disclosure preferences; involve family where appropriate; respect modesty; adapt greetings/touch; provide culturally appropriate meals and religious/prayer space	"Patient preferred family-mediated discussion of serious news; female clinician performed examination; patient kept religious garment on during noninvasive care."	Use of cultural accommodations; patient/family partnership indicators; interpreter use; family involvement practices

Peterson et al. [62] propose a three-step framework for implementing SDM: (1) identify domains requiring support (e.g., medical, financial, or personal); (2) determine the type of assistance—communication aids, trusted companions, interpreters, or additional time for deliberation; and (3) ensure institutional or legal recognition of supported choices. This approach is designed to secure the person's voice as authoritative rather than representative.

Ethically, SDM embodies relational autonomy: autonomy understood not as independence from others, but as exercised and sustained through relationships of support, dependence, and trust. Reliance on others to articulate or enact choices does not negate self-determination; it reflects the social conditions of human agency. In this way, SDM operationalizes dignity as standing, recognizing persons not for cognitive independence but for their capacity to hold and express values within relationships of care.

One concrete way to operationalize SDM in mental health services is through embedding trained peer support workers (with lived experience) in multidisciplinary teams, which service users describe as fostering hope and recovery while peer workers report increased self-esteem and usefulness within care [63]. However, although peer support may improve some outcomes (e.g., aspects of recovery and, in some populations, depressive symptoms), dignity-preserving implementation depends on role clarity, training and supervision, and a supportive organizational culture rather than tokenistic inclusion [64].

Further empirical evidence reinforces this model. Mattos et al. [65] show that patients with moderate dementia can convey stable values when supported, while Daly et al. [66] find that clinicians often underestimate this retained capacity, fostering unnecessary paternalism. Poppe et al. [67] likewise emphasize that capacity assessments in dementia require context-sensitive methods that attend to patients' values, preferences, and situational understanding instead of relying solely on cognitive testing. Accordingly, targeted training and structured SDM frameworks operationalize these insights, ensuring that clinical decisions honor the patient's agency rather than displace it.

3.3. Respecting value-based refusals

Beyond the mechanics of support, upholding dignity also requires honoring the values that ground a person's refusals—even when reasoning or comprehension is limited. Traditional assessments of decision-making capacity often rely on a comparative model, which demands that patients rationally weigh and contrast all available options. Navin et al. [68] challenge this standard, arguing that it risks dismissing refusals that, though not analytically reasoned, still express morally significant values and commitments. They propose burdens-based and goals-based forms of decision-making capacity: a patient may justifiably refuse treatment if all available options impose intolerable burdens, or if the proposed treatment conflicts with a deeply held life goal. Such refusals can retain moral authority even when comparative capacity is lacking.

For instance, an older adult might not grasp the medical distinctions between chemotherapy and surgery yet may clearly state, "*I don't want anything that keeps me bedridden*". When every treatment would result in that outcome, this consistent value judgment provides an ethically valid basis for refusal. Similarly, a patient may prioritize attending a family milestone over a life-prolonging procedure, revealing a meaningful hierarchy of values even without fully understanding comparative risks and benefits.

Recognizing such value-based refusals reframes autonomy not as the capacity for technical deliberation, but as the ability to articulate what truly matters to one's identity and sense of self [59]. It aligns with dignity as standing by affirming that persons remain moral agents whose voices carry weight, even when their reasoning is impaired. In practice, clinicians should give moral authority to long-standing preferences, personal narratives, and affective expressions of meaning, rather than treating cognitive imperfection as moral silence.

3.4. Relational and structural supports

Truly upholding dignity in healthcare requires more than protecting autonomy at the moment of decision; it depends on the relationships, environments, and systems that shape how people are seen and treated. Dignity as standing cannot survive in settings where patients feel unseen, unheard, or reduced to their diagnoses. It must be sustained through both compassionate relationships and institutional structures that affirm the patient's status as a person of equal worth.

Relationally, dignity is enacted through communication, trust, and inclusion. Chambers et al. [28] found that involuntarily detained psychiatric patients often experienced their dignity as routinely violated—through being ignored, excluded from decisions, deprived of information, and confined in punitive or depersonalized spaces. Such treatment, even when justified by beneficence, left patients feeling dehumanized and hopeless. Conversely, when staff took time to listen, explain, and involve patients in decisions, their sense of self and motivation for recovery strengthened. The lesson is clear: preserving dignity is not merely a moral ideal but a therapeutic necessity. Everyday practices—listening to patients, using respectful language, ensuring privacy, minimizing coercion, and creating calm, humane environments—restore a patient's sense of standing within the moral community and foster the trust on which healing depends [69, 70].

This is especially salient in involuntary mental health contexts: qualitative evidence shows that clear information, involvement, and collaborative staff relationships can mitigate the dignity-threatening effects of coercive care [71]. A trauma-informed approach strengthens this point by treating trauma exposure as a "*universal precaution*" and operationalizing dignity through safety, collaboration, and patient control in everyday clinical encounters to reduce the risk of re-traumatization [72]. At the level of the built environment, systematic identification and abatement of suicide hazards through an environmental safety checklist has been associated with a substantial reduction in completed suicides in a large national hospital system [73]. At the level of staff practice, cluster-randomized evidence suggests that structured de-escalation training can reduce both the frequency and duration of physical restraint and lower restraint-related adverse events in psychiatric wards [74]. Complementing these targeted strategies, implementation of the Six Core Strategies in an adolescent inpatient facility eliminated seclusion and substantially reduced restraints while also reducing staff absenteeism, illustrating how dignity commitments can be embedded through service-wide culture change rather than isolated fixes [75].

At a structural level, dignity depends on the broader social, political, and institutional scaffolding of care [76]. Social determinants such as poverty, discrimination, housing insecurity, limited education, and language barriers profoundly affect a person's ability to exercise agency [77]. When these factors go unaddressed, patients may appear "*noncompliant*" or "*disengaged*", when, in fact, the system has failed to accommodate their circumstances. In low-resource settings, dignity threats extend beyond clinical walls: interviews with people recovering from severe mental illness in Uganda describe psychological devaluation, physical confinement and violence, and sexual victimization—often within families—with downstream harms including social withdrawal and heightened suicide risk [78]. Relational supports—such as interpreters, cultural mediators, patient advocates, attentive caregivers, and community health workers—make participation in care possible, so that linguistic, cognitive, and socioeconomic vulnerability does not translate into moral invisibility. In practice, this may

involve connecting patients to housing, food, and transportation resources and helping them navigate fragmented systems of care [79], facilitating communication and addressing cultural misunderstandings between patients and providers [80], simplifying medical explanations and adjusting interactional styles to sustain patients' sense of agency [81], and fostering open communication, honoring residents' daily preferences, and creating humane routines—such as flexible schedules, social activities, unhurried and respectful personal care, and opportunities to develop meaningful relationships with other humans, animals, and plants—that preserve dignity in long-term care institutions [82].

One practice-oriented response to these structural and familial vulnerabilities is a Uganda based pre- and post-discharge home intervention designed to strengthen caregiver support and community-based care and thereby reduce overcrowding and readmissions where formal services are scarce [83]. A long-standing system-level illustration of dignity-preserving community care is the Trieste model, which replaces institutional dependence with a network of 24/7 community mental health centers, supported housing, and partnerships with social cooperatives that prioritize continuity, recovery, and social inclusion [84]. A multi-year follow-up of patients experiencing acute mental health crises managed through these community services reported favorable outcomes, including low relapse rates, no suicides, and no dropouts [85].

Empirical research across acute, geriatric, and mental health settings shows how dignity is sustained through everyday practices and reinforced by training, environments, and organizational supports. Baillie [86] and Woolhead et al. [87] demonstrate that addressing patients by name, speaking to them directly, and ensuring privacy during care foster a deep sense of respect, whereas depersonalizing habits—such as discussing patients in the third person—erode it. Training and reflexivity programs, such as those outlined by Buonaccorso et al. [88], can embed this awareness into professional conduct. Their review recommends ongoing, culturally attuned, interprofessional education that blends didactic teaching with experiential methods to help clinicians recognize and address threats to patients' dignity, including immersive simulations (e.g., living as residents in a simulated care home), sensory-deficit labs, simulated patient encounters with video-recorded debriefing, reflective diaries with supervised application, and narrative dignity interventions. One such intervention, Dignity Therapy, uses a structured interview to elicit patients' values, memories, relationships, and hopes, which are transcribed, edited, and returned as a legacy document. Clinically, it functions as an antidote to hopelessness, loss of meaning, concerns about being a burden, and illness-related identity erosion [89], and—although developed for end-of-life care—may be especially relevant in contexts such as early dementia [90].

Beyond individual interventions, institutional and system-level design reinforces these relational practices: private rooms, accessible facilities, and provider continuity all contribute to sustaining dignity, especially for those in long-term care [91, 92]. Making dignity a measurable indicator of care quality—through patient feedback on respect, communication, and inclusion—would further institutionalize these practices [93]. At the primary care level, a cluster randomized intervention combining a community anti-stigma campaign with mobile electronic decision support for frontline workers reduced depressive symptoms and increased remission among adults at high risk in rural India, even though measured help-seeking behavior for mental health did not improve [94].

It is worth noting that care practices are often shaped by risk-averse institutional policies (e.g., capacity assessments, privacy rules, safeguarding procedures, and liability concerns), with the result that dignity-relevant needs in long-term care and residential mental health settings (e.g., intimacy, touch, and companionship) are framed narrowly in terms of consent and safety compliance. Empirical work shows that this compliance-oriented framing frequently sidelines well-being and care values, leading staff to default to risk management rather than structured, person-centered care [48–50]. Training and policy materials should therefore be reconsidered in light of the multifarious applications of dignity as standing, and revised to operationalize dignity as a practical standard for everyday judgment, not merely as a legal constraint. This would better enable providers to respond to individual patient circumstances.

Finally, structural reforms must entrench dignity at the policy level. Legal analysis of Victoria's Mental Health and Wellbeing Act (2022) in Australia shows that "*rights-based*" framing can coexist with largely unchanged coercive criteria: despite some rights-related improvements, the Act retains diagnosis-based coercive powers and does not give binding force to capacity, advance preferences, or a will-and-preferences approach, indicating that dignity must function as a practical constraint on institutional power rather than as aspirational language alone [95]. Laws governing capacity, consent, and involuntary treatment should promote decision-making that respects autonomy and minimizes coercion [96]. A recent scoping review of deinstitutionalization highlights why this is difficult in practice, identifying recurring barriers such as medical-model dominance (a symptom- and medication-focused approach that sidelines social reintegration), transinstitutionalization (shifting to other institutions), under-resourced community alternatives, and discrimination, alongside drivers such as independent housing, individualized support, and consumer participation in services [97]. Within these structural limits, one concrete safeguard is the legal recognition of advance directives for mental health, which can preserve patients' voices even during incapacity [98, 99].

As Marmot [77] underscores, inequality and exclusion corrode the very conditions for dignity. The COVID-19 pandemic revealed this on a global scale—not only through underfunding, but through the normalization of structural ageism. Sweden's experience, despite its advanced welfare system, illustrated how deep-seated age biases and delayed protective measures rendered older adults socially invisible: nearly half of early pandemic deaths occurred in nursing homes, exposing systemic neglect that treated older lives as secondary [100]. Sustaining dignity, therefore, requires more than empathy; it demands redesigning the moral architecture of care and society itself so that every individual—regardless of mental status, age, ability, or social standing—is treated not as a burden to be managed but as a *person* to be recognized.

3.5. Cultural inclusion

While the obligation to uphold dignity binds us all as a universal moral value, the ways in which it is recognized, protected, and expressed differ across cultures [101, 102]. What counts as "*dignified*" or "*humane*" care varies with traditions, languages, and social norms—even when the underlying sense of human

worth is shared [103]. A dignity-as-standing framework therefore cannot impose a single script; it must be culturally attuned, translating shared moral duties such as respect, inclusion, and non-humiliation into forms that resonate with the patient's cultural and ethical horizon. For healthcare professionals, this demands not only ethical commitment but also cultural awareness and competence, as well as an understanding that the same universal value may take different, yet equally valid, expressions across communities [104, 105].

A recurrent contrast illustrates this point. In many Western, individualist settings, dignity is closely tied to autonomy, privacy, and self-expression—hence the ethical emphasis on informed consent, direct disclosure, confidentiality, and minimal paternalism. By contrast, many collectivist traditions ground dignity in belonging—maintaining family involvement and avoiding the appearance that an elder has been "*abandoned*" to decide alone [106]. In some communities, respect is expressed by doing for elders to honor their status; in others, by enabling elders to do in order to preserve independence. For instance, in East Asian contexts shaped by Confucian filial piety, an older patient may feel more dignified when adult children are consulted, whereas a Western elder in the same situation might feel infantilized. Neither approach is inherently more dignified; under a dignity-as-standing framework, person-centered care must remain attentive to cultural context.

How does a dignity-as-standing framework operationalize cultural inclusion in practice? A recurrent theme reflecting the individualist–collectivist divide appears in attitudes toward truth-telling at the end of life. In some cultures—particularly in East Asia, the Middle East, and Latin America—withholding a terminal diagnosis is seen not as deception but as compassion, a way of preserving hope and protecting the person's "*face*" [107]. In others, especially in Northern Europe and North America, concealment is viewed as an affront to dignity because it undermines agency. From a dignity-as-standing perspective, the former approach may affirm the person's social role and shield them from psychological distress, yet it can conflict with the dignity-as-autonomy view that equates respect with full disclosure.

In such cases, dignity as standing calls for negotiated openness: rather than assuming one default (e.g., "*always disclose directly to the patient*" or "*avoid telling the patient distressing news when the family insists*"), clinicians should elicit preferences early through gentle inquiry—for example, by asking how the patient would like to receive information, how much and what kind of detail they wish to know, and whether such conversations should take place with them directly or involve their family first. Such dialogue embodies a practical reconciliation between universal respect for personhood and the inclusion of patients' cultural norms and values.

Healthcare providers must also be attuned to the gestures, communication styles, and norms that each culture associates with dignity or offense. In Chinese and other East Asian settings, a slight bow—even to someone only a year older—and the use of honorific language are traditional signs of dignity and deference [108]. An East Asian elder may therefore expect such formalities and find an overly casual, first-name approach undignified. Similarly, prolonged eye contact—often read as attentiveness in Western contexts—can feel intrusive or disrespectful in parts of East Asia [109]. In many Muslim societies, dignity is closely linked to modesty: women may request female providers, keep their hair covered, and avoid gowns they find too revealing [110].

Elsewhere, meanings shift again—many African cultures express dignity through warm handshakes and lively greetings, while in conservative Muslim settings physical contact between unrelated men and women is often avoided [111]. In Latin American and Mediterranean contexts, a caring touch or embrace is seen as comforting and dignifying, consistent with more tactile social norms; by contrast, cultures of Northern European origin, including British, German, and some North American contexts, may view non-clinical touch as intrusive [112]. In some South Asian cultures, including India, one waits for an elder or a woman to extend a hand first, and only the right hand should be used for greeting or assistance, as it symbolizes purity and propriety [113].

These contrasts show how a single gesture can embody opposite meanings across cultures. Dignity-centered care therefore demands more than courtesy—it requires culturally inclusive engagement with the social codes through which dignity is expressed. Addressing an older patient as "*Mr.*" or "*Madam*" may affirm dignity in one setting, while in another, a gentle touch or warm tone conveys it more naturally. From a dignity-as-standing perspective, it is this cultural attunement that transforms dignity from an abstract ideal into a lived, recognizable form of honor.

Cultural inclusion in dignity-centered care extends beyond mannerisms and communication styles to the full spectrum of institutional design, policy, and practice. Offering meal options that are halal, kosher, vegetarian, or vegan; adjusting schedules around major cultural or religious holidays; and providing space for prayer or quiet reflection signal that patients are valued as whole persons, not merely as medical cases [114]. Physical environments can likewise convey respect—through signage and educational materials in the community's languages, artwork representing its people, or family-friendly wards when communal support is central to dignity [115]. In long-term care, allowing residents to decorate their rooms with familiar cultural symbols or organizing activities that celebrate their heritage helps affirm both identity and belonging. Healthcare teams can further sustain this awareness by collaborating with cultural mediators and community leaders who can illuminate what counts as dignified treatment within specific populations.

Religious and spiritual practices often provide powerful expressions of dignity-as-standing. In South Asian Hindu contexts, for example, feeding patients pure (sattvic) foods—free of meat, onion, and garlic—and providing a small space for puja (prayer) at the bedside nurture spiritual dignity [116]. In some Native American and First Nations traditions, rituals such as smudging with sage or sprinkling holy water cleanse spiritual harm and restore balance [117]; healthcare facilities can accommodate these ceremonies safely in ventilated rooms, with staff trained to step out respectfully [118]. Among Muslim and Orthodox Jewish women, modesty forms a key component of dignity, requiring female clinicians for intimate examinations and hospital gowns that are not overly revealing [110, 114]. Similarly, permitting patients to keep religious garments—such as a turban, hijab, or crucifix—when medically feasible, or adjusting fasting and prayer schedules during Ramadan or the Sabbath, demonstrates that care extends to the person's moral and spiritual identity, not just their body.

Linguistic and relational dimensions matter as well. Providing professional interpreters and bilingual staff ensures that patients with limited language proficiency can fully participate in decisions that affect them [119]. For Deaf patients who use sign language, maintaining eye contact, staying within the visual field, and allowing sufficient time for interpretation are integral to dignified communication [120]. In family-centered cultures, rigid visiting hours can inadvertently erode dignity by excluding essential sources of support. Flexible visitation policies that treat family as partners in care rather than "*visitors*" both affirm belonging and improve safety, as relatives often assist in care and advocate for patient needs [121, 122].

At the institutional level, training programs should embed these insights into professional practice [123, 124]. Mandatory cultural competence modules—featuring demonstrations of greetings (bowing, cheek-kissing, handshakes), rituals (ablution, puja, smudging), and communication styles (direct versus indirect disclosure)—can help clinicians navigate diverse norms confidently and respectfully.

In embracing these strategies, healthcare systems operationalize a central moral insight: equal dignity does not mean identical treatment. It means honoring each person's worth by meeting them where they are—spiritually, culturally, and socially. This culturally adaptive, dignity-as-standing–aligned approach does not relativize the principle of dignity; rather, it refines it, translating universal respect into concrete, context-sensitive forms. The result is care that not only heals or comforts, but also affirms human dignity in all its diversity.

4. Conclusions

We have argued that dignity as standing—the idea that to have dignity is to occupy the elevated rank of being human, and that every interaction should reflect the honor this rank deserves—offers a more action-guiding and clinically applicable framework than appeals to inherent, non-natural, metaphysical value. This is because dignity as standing provides a concrete description of what the dignified being is, and it is precisely this description that makes it easier to discern how to treat that being appropriately. Looking ahead, the task is to bring this framework to life—to build systems of care that recognize dignity not as an abstract right but as a daily practice of equality and recognition. A culture of dignity begins when no one is treated as less than human: when the confused elder is greeted with warmth, the psychiatric patient is seen beyond their diagnosis, and every person is regarded as a member of our shared moral community, where each being's dignity is bound to our own. Only when this ethos is internalized will structural reforms take root, enabling people of all capacities to live—and die—with their dignity intact.

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